# HEALTH AUTHORITY BUSINESS PLAN AND ANNUAL REPORT REQUIREMENTS

## 2000-2001 TO 2002-2003

December 1999

Alberta
HEALTH AND WELLNESS

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# Health Authority Business Plan and Annual Report Requirements

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# 1. Introduction

**Vision**
The Government of Alberta's vision for the province is: ***"A vibrant and prosperous province where Albertans enjoy a superior quality of life and are confident about the future for themselves and their children."***

- In this context, our vision for health is ***"Citizens of a healthy Alberta achieve optimal health and well being".***

Source: Draft Ministry of Health and Wellness Business Plan 2000/2001 to 2002/2003

**The Business Plan:**

Defines responsibilities:
- core businesses
- goals to be achieved
- strategies to achieve goals
- performance measures and targets.

Reports on plans to stakeholders about resource allocation and strategies.

This document provides information on the components required from health authorities for 2000-2001 to 2002-2003 business plans and for 1999-2000 and 2000-2001 annual reports.

The business plan is an accountability document. It provides a statement of health authority responsibilities (core businesses) and results to be achieved (goals). It indicates how responsibilities will be carried out to achieve results (strategies), and how progress will be measured (performance measures and targets). Once approved, the health authority business plan becomes an agreement between the Minister of Health and Wellness and the health authority on what is to be accomplished and how it will be done.

The business plan is also a planning report. It communicates direction, goals and strategies to staff, public and other stakeholders. It allocates resources to deliver services, implement strategies and achieve goals. It integrates plans across the government, the ministry and health authorities to achieve provincial goals in health.

Health authority business plans should be based on a broad definition of health, reflecting a determinants of health approach, which considers the influence of a range of factors on health status. The broad government vision is reflected in: ***"Healthy Albertans in a Healthy Alberta"***. Within this context, the vision of Alberta Health and Wellness is:

> ***"Citizens of a healthy Alberta achieve optimal health and well being".***
>
> The Ministry vision acknowledges that the determinants of the health and wellness of a population include factors such as education, employment, income and the environment. This vision is comprised of two distinct but interwoven dimensions:
>
> - Albertans are able and encouraged to realize their full health potential in a safe environment, with adequate income, housing, nutrition and education, and to play a valued role in family, work and their community, and
> - Albertans have equitable access to affordable and appropriate health and wellness services of high quality.

The achievement of the Ministry vision requires individuals to take responsibility for health in their communities, in collaboration not only with the Ministry and providers of health services, but with a wide variety of parties including other Ministries, other levels of government and the private sector

Source: Draft Ministry of Health and Wellness Business Plan 2000/2001 to 2002/2003

**Key Challenges:**

- ensuring Albertans get the care they need
- preparing for the future
- improving accountability and results
- focusing on long term health gains

Source: Ministry of Health and Wellness Business Plan 1999/2000 to 2001/2002

Business Plans should reflect the strategic directions for the health system, address key challenges identified by the Ministry of Health and Wellness and be consistent with the ***Government's Commitment to Health:***

- *Albertans will have access to quality health care services when they need them.*
- *High standards will be set, results will be measured and monitored and Albertans will receive regular reports about outcomes in health.*
- *Control of Alberta's health system will continue to be in the public sector, with leadership by the provincial government, management by health authorities, delivery by health care providers and accountability at every level.*
- *Albertans will be insured for medical and hospital services. Medically necessary health services will be available to all Albertans without user fees, extra billing or other barriers to reasonable access.*
- *A solid base of resources will be available to support Alberta's health system, people, dollars, equipment, facilities, research and ongoing education.*
- *Alberta's health system will balance the need to provide quality care for those who are ill or injured with strategies to keep people healthy and well.*
- *Decisions about changes in Alberta's health system will be based on the best information available and will have a single objective: to improve health care and the health of Albertans.*
- *Albertans will be well informed and involved in decisions about their own health, their community's health care system and directions for ongoing health reform in the province.*

Source: Ministry of Health and Wellness Business Plan Update, 1997-1998 to 1999-2000

Health authority business plans and annual reports are submitted to and approved by the Minister of Health and Wellness in compliance with legislation as follows:

- Regional Health Authorities: *Government Accountability Act* and the *Regional Health Authorities Act*
- Alberta Mental Health Board: *Provincial Mental Health Board Regulation* authorized by the *Regional Health Authorities Act*
- Alberta Cancer Board: business plan submitted under the *Government Accountability Act;* annual report submitted in accordance with the *Alberta Cancer Programs Act.*

Health authorities are responsible for carrying out their business plans, reporting progress and results, and explaining any variation between planned and actual performance. This is done formally in the annual report at the conclusion of the year. Performance during the year is monitored through on-going and ad hoc reporting processes, e.g. quarterly reports. In addition, information will be required routinely to keep the funding formula current for regional and province-wide services.

The annual report is an important source document for developing the next business plan. It informs Albertans about both achievements and priorities for improvement that should be addressed in the next business plan. Developing business plans and reporting on the results achieved are key to establishing processes for continuous improvements in health services. Information from health authority business plans and annual reports is used in the development of the Ministry business plan. Business plans and annual reports are public documents. The complete plan and annual report are to be available to the public on request.

## 2. The Link Between Ministry and Health Authority Business Plans and Annual Reports

The requirements provide a provincial framework for development of business plans by the Regional Health Authorities, the Alberta Cancer Board and the Alberta Mental Health Board. Provincially required goals link the strategies and operations of health authorities with the Ministry plan, which sets strategic directions for the health system as a whole.

The Minister of Health and Wellness is accountable to the Legislature for the overall direction and operation of the health system in Alberta. The Ministry business plan provides the vision and strategic direction for the health system, goals and strategies that Alberta Health and Wellness will implement, and key performance measures that will be reported to assess results achieved by the system. Information about performance, progress toward the goals and areas for improvement is provided in the Ministry of Health and Wellness annual report.

The requirements outlined in this document provide a provincial framework for development of business plans by the Health Authorities. The requirements are based on a draft of the 2000-2001 to 2002-2003 Ministry of Health and Wellness Business Plan. Provincially required goals are established in this document for all health authorities. These goals link the strategies and operations of health authorities with the Ministry plan, which sets strategic directions for the health system as a whole.

Subject to this Act and regulations, a Regional Health Authority

(a) shall

(i) promote and protect the health of the population in the health region and work towards the prevention of disease and injury;

(ii) assess on an ongoing basis the health needs of the health region;

(iii) determine priorities in the provision of health services in the health region and allocate resources accordingly;

(iv) ensure that reasonable access to quality health services is provided in and through the health region; and

(v) promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

Section 5, *Regional Health Authorities Act*

**Annual Reports** show the results achieved on each provincial and regional goal identified in the corresponding year's business plan.

**Business Plan Submission**

**Business Plans are due eight weeks after health authorities are advised of their budgets.**

15 copies, including 1 copy unbound, should be sent to the Minister of Health and Wellness

The development of business plans provides opportunities for health authorities to work with each other, their communities, community health councils, professional/technical committees and other stakeholders. Broad-based consultations and involvement help define health needs and identify priorities for health and health services. They also provide input on how those priorities can best be met.

Health authorities are responsible for the delivery of core health services as defined in *Core Health Services in Alberta,* (June 1994) and subsequent directives. Health authorities outline in their plans how core health services will be used to address health needs and priorities. They are responsible for choosing strategies that will achieve the shared goals set out by the Minister of Health and Wellness and additional goals specific to the needs of the communities served.

Health authority annual reports show the results achieved on each provincial and regional goal identified in the corresponding year's business plan. Performance information is provided to allow for assessment of progress in implementing strategies and achieving goals. Information contained in annual reports and information from many other sources informs decision-making about future directions.

The health authority business plan and annual report requirements outlined in this document will meet, in part, the reporting and accountability requirements for health authorities as accountable organizations under the *Government Accountability Act*. Other ad hoc and ongoing reporting activities are still necessary.

## 3. Submission, Review and Approval of Business Plans

Business plans are to be concise documents of 15 to 20 pages. Business Plans are intended to show the direction that the region is taking. Detailed program and service plans, implementation plans and work plans are <u>not</u> required to be submitted. Health authorities may choose to release other documents that complement the business plan for a variety of audiences.

Business plans are to be submitted to the Minister of Health and Wellness **within eight weeks after Health Authorities are advised of their funding for the fiscal year.** The business plan, and any amendment or addendum to the business plan, requires approval by the health authority board prior to submission.

**The Minister reviews the business plans to ensure that plans address:**

- **all required components,**
- **strategic directions established for the health system,**
- **health status or system performance issues identified in annual reports and other documents or reports, and**
- **any directions from the Minister.**

Health Authorities are welcome to discuss their business plans with Ministry representatives. Ongoing informal communication will occur between Alberta Health and Wellness and health authority staff throughout the business planning process to facilitate the development and approval of business plans. Additional information may be requested by Alberta Health and Wellness to clarify the plan and support the strategies, if required. Informal feedback on the health authority business plan, for those business plans received on time, will be provided to the health authority's business plan contact person within six weeks of submission.

The Minister determines whether a business plan is acceptable as written or whether it requires adjustment. Formal feedback on the business plan is provided to each health authority board chair by the Minister.

Health authority budgets are approved with the business plans. Approved plans are tabled in the Legislative Assembly. A business plan that is not approved is returned to the health authority with a request for revisions and the date by which a revised plan is required. The revised business plan requires board approval.

## 4. Assumptions and Risks

**Separate submission to the Minister at the same time as the Business Plan**

- Assumptions and Risks

Assumptions should provide **three years** of historical data and **three years** of projections.

Assumptions and Risks are the significant underlying factors that provide the basis for development of the health authority business plan.

Assumptions and Risks are to be submitted as a separate document with the business plan.

### Developing Assumptions and Risks

Assumptions and Risks are developed by analyzing the current and projected future of the health authority, its external environment and key internal variables. This analysis is an opportunity to present the health authority's view of its challenges and opportunities, its view of its current and future

reality. The importance of the analysis cannot be overstated, as it provides the foundation and rationale for the health authority's business plan. As such, the analysis should be comprehensive, yet focused on the key variables impacting strategy selection, to adequately convey the reasons for the strategies and performance targets being proposed in the business plan. In addition, the analysis should recognize the unique circumstances and challenges of each health authority. A solid overview of Assumptions and Risks should support a discussion of the planning decisions that are being made.

The presentation of Assumptions and Risks should take into account both quantitative and qualitative analysis. A qualitative analysis would consider critical factors, such as community and organizational beliefs and attitudes about health and health service delivery, and potential policy changes.

A similar balance must be struck between historical data and future projections. Even though forecasts can be uncertain, they are necessary for the purpose of direction-setting and performance measurement/management. Organizational performance is strengthened by direction-setting, continuous monitoring and adjustment, and contingency planning that is generally represented by an analysis of Assumptions and Risks. Therefore, for all important variables that are quantifiable (e.g., population projections, financial resources, service volumes), three years of historical data and three years of projections are to be provided.

**Assumptions Categories**

Significant assumptions should be identified from among the following broad categories:

- **Regional demographics and epidemiology** – this should cover off not only overall population change but also identify trends in key subgroups (e.g., seniors, ethnic groups, children and youth) and health status (e.g., heart disease, accidents).
- **Community/Client/Key Stakeholder expectations** – key variables, often times non-quantifiable but important, as they relate to expectations for health services delivery.
- **Regional economic trends** – this should cover off those developments most likely to impact population trends, population health status and service expectations (e.g., local commercial/industrial development).
- **Service volumes** – identify anticipated changes in service volumes particularly in high cost delivery areas/programs and in those services identified as being integral to the organization's mission/vision.

- **Clinical advances** – this would include any projected developments in technology, clinical knowledge, and changes in service delivery models with the potential to significantly impact service delivery, resource requirements, outcomes and overall performance.
- **Human resources** – this would include labour relations (e.g., level of collaboration/conflict, contract settlements), availability of key resources (including physicians and volunteers), changes in scope or capabilities of personnel (e.g., training requirements).
- **Financial and other resources** – including multi-year projections of revenue (government and non-government), expenditures (broken down into categories of expenses relevant for communicating opportunities and challenges to an external reader), capital plans, and information technology/information management.
- **Regional and province-wide relationships and developments** – identification of trends in intra-regional (e.g., with voluntary and private providers), inter-regional (e.g., with other health authorities), inter-sectoral (e.g., with education, social services, local government) and provincial relationships (e.g., implications of implementation of recommendations of the Long Term Care Review Committee).

The significant assumptions will together create a forecast that, along with the health authority's mission/vision, will determine the strategic choices in the business plan.

**Risks and Contingency Planning**

No forecast is ever completely reliable, and this uncertainty must be taken into account by an analysis of Risks. An analysis of risks should identify the sensitivity of the business plan to changes in key assumptions and establish contingencies in the event such risks are realized. A determination of which risks are documented in the analysis should be based on degree of uncertainty, degree of potential impact on mission/vision/goal achievement, and extent of consequences to the health authority. The analysis should then document the contingency plans that are in place to manage the realization of these significant risks (e.g., balanced budget projection versus operating deficit may imply delay in implementing new initiatives) so that overall health authority goals and objectives remain achievable. This speaks directly to issues of sustainability, priorities relative to achievement of health authority vision, and choices within the context of available resources.

## 5. Audited Financial Statements

**Audited Financial Statements 1999-2000**
**Due June 30, 2000**
**Audited Financial Statements 2000-2001**
**Due June 30, 2001**
2 copies to Minister of Health and Wellness

Audited Financial Statements are required under the Regulations to be submitted by **June 30** following the end of the fiscal year to which they relate. Timely submission is critical because the information is used in preparing the Ministry of Health and Wellness annual report.

## 6. Submission and Review of Annual Reports

**Annual Reports 1999-2000**
**Due July 31, 2000**
**Annual Reports 2000-2001**
**Due July 31, 2001**
15 copies - including 1 copy unbound to Minister of Health and Wellness

Annual Reports are required under the Regulations to be submitted by **July 31** following the end of the fiscal year to which they relate. Updated data to support health authority annual reports will be provided by Alberta Health and Wellness by June 15, 2000. All performance measures and targets identified in the business plan are to be reported on in the annual report. The Minister of Health and Wellness reviews annual reports to ensure all required components are included, and to assess its value as an accountability document. Variations from plans and impacts on performance are assessed. Health Authorities are welcome to discuss their annual reports with Ministry representatives. Information from health authority annual reports is analyzed by the Ministry for use in the next planning cycle. The Minister of Health and Wellness may provide specific direction to health authorities based on results reported in annual reports or through ad hoc or other routine reports.

## 7. Quarterly Reports

Quarterly reports are to be prepared and submitted to Alberta Health and Wellness within 60 days after the end of each quarter. The financial quarterly reports must be prepared in accordance with the requirements set out in FD14 and subsequent directives. The reports are due June 30, September 30 and December 31. Management discussion and analysis of the report is required. Audited financial statements are provided in place of a fourth quarter financial report. Quarterly Reports on program issues may be required by the Minister to monitor progress on areas of particular concern.

## 8. Components of Health Authority Business Plans

**Required Components of Health Authority Business Plans**

- Statement of Accountability
- Vision
- Mission
- Opportunities and Challenges
- Core Businesses
- Goals
- Strategies (including province-wide services where relevant)
- Performance Measures, Targets and Key Indictors
- Long Term Capital Plan
- Financial Information
- Overview of Information Management, we//net, technology plan
- Health Workforce Plan

**Separate submission at the same time as the Business Plan submission**

- Risks and Assumptions

Health authorities are responsible for the effective governance and management of their health region to ensure accountability and continuous improvement in the health system. This includes:

- establishing a clear vision and mission;
- assessing and monitoring the health status and service needs of communities and residents;
- determining health and health service priorities;
- allocating and managing resources based on needs assessment, other evidence, and the provincial framework of legislation, policy and standards;
- monitoring and reporting on progress;
- evaluating performance; and
- investing in innovation.

The requirements outlined in this document apply generally to Regional Health Authorities, the Alberta Cancer Board and the Alberta Mental Health Board.

Some requirements may be adjusted to apply to the Alberta Cancer Board and the Alberta Mental Health Board.

The Minister of Health and Wellness may identify specific requirements for individual health authorities, in relation to areas needing improvement, or in relation to province-wide services.

**Province Wide Services**

Calgary Regional Health Authority and Capital Health Authority must include relevant planning and results information relating to Province Wide Services so that the business plan is sufficiently comprehensive to enable assessment of performance.

**Format**

Health authorities can develop any format useful to present their business plans, as long as the required components are included and easily identifiable. The business plan should be no longer than 20 pages.

**Required components** that must be included in all health authority business plans are described below. Appendix VII Planner's Checklist for the Business Plan is recommended for use by planners to ensure that all required components are included in business plan submissions.

## 8.1 Statement of Accountability

**Required Statement of Accountability**
This business plan for the three years commencing April 1, 2000 was prepared under the Board's direction in accordance with the *Government Accountability Act, Regional Health Authorities Act* and directions provided by the Minister of Health and Wellness. All material economic and fiscal implications known as at _____, 2000, have been considered in preparing the business plan.

The _____ Health Authority's priorities outlined in the business plan were developed in the context of the Ministry of Health and Wellness's business and fiscal plans. We are committed to achieving the planned results laid out in this business plan.

Respectfully Submitted on Behalf of
_____ Health Authority,

Signed by Health Authority Chair

- confirms the business plan was developed in accordance with appropriate legislative authority and government requirements
- signifies commitment of the health authority board to achieve the results indicated in the plan
- uses the wording specified in the left margin

## 8.2 Vision

- consistent with and builds on the Alberta Health and Wellness vision for health: ***"Citizens of a healthy Alberta achieve optimal health and well being".***
  Source: Draft Ministry of Health and Wellness Business Plan 2000/2001 to 2002/2003
- focuses on the future health of Albertans and the health system

## 8.3 Mission

- clearly states the reasons why the health authority exists
- describes how the health of Albertans will be different as a result of the health authority's actions
- relates how the health authority will work to reach its vision and contribute to the vision for health and wellness in Alberta
- the mission of the Ministry of Health and Wellness is ***"...to maintain and improve the health of Albertans by leading and working collaboratively with citizens and stakeholders."***
  Source: Draft Ministry of Health and Wellness Business Plan 2000/2001 to 2002/2003

## 8.4 Opportunities and Challenges

- identify opportunities and issues facing the health authority that need to be considered when developing goals, strategies, measures and targets for business plans
- business plan opportunities and challenges should link with the results, challenges and future directions from the previous year's annual report
- the business plan should indicate how challenges will be managed or addressed and how opportunities will be used to advantage
- highlight any new innovations that will be implemented
- highlight the major priorities for the health authority in the coming year.

## 8.5 Health Authority Core Businesses

**Required Core Businesses**

1. Ensure delivery of quality health services.
2. Encourage and promote healthy living.

- brief statements of the health authority's responsibilities, which are based on Section 5 of the *Regional Health Authorities Act* and apply broadly to the Cancer Board and the Mental Health Board.
- required core businesses are defined for all health authorities
- additional core businesses may be identified by health authorities
- further definition of the core businesses is provided below:

**Core Business 1: Ensure delivery of quality health services.**

**Dimensions of Quality**

Dimensions of quality in the health system include: appropriateness, effectiveness, safety, efficiency,. accessibility and acceptability.

Source: *Health and Health System Expectations and Measures: A Consultation Paper,* March 1998)

- Health authorities are responsible for sustaining and improving the delivery of quality health services. These include the full spectrum of health services for individuals and for communities. Health authorities also contribute to the overall functioning of the health system and are responsible for continuity of care, coordination of service delivery with other sectors and integration of health services.

**Core Business 2: Encourage and promote healthy living.**

- Health authorities are responsible for supporting and encouraging the well-being and health of citizens. Health promotion and protection programs, disease and injury prevention programs, along with enhanced supports for persons with disabilities, address risks to health where knowledge or early intervention can make a major difference. Health authorities and provincial agencies provide programs and services for the promotion of well-being, as well as the prevention of disease and injury, to enable Albertans to make informed decisions about their health. Health authorities also contribute to improvement in the health of the population by advocating for health and healthy public policy; and by effectively communicating and working with communities, service providers and other sectors.

(Source: Based on the draft Alberta Health and Wellness 2000 – 2003 Business Plan and the Health Authority Business Plan and Annual Report Requirements 1999-2000 to 2001-2002)

## 8.6 Goals

- provide broad statements of desired results that are potentially attainable
- health authorities are required to include the four goals set by the Minister of Health and Wellness, which are presented later on pages 15 to 18. The objectives that follow each goal describe more completely the intent and scope of the goal. It is not required that the exact wording of the objectives be included in the Health Authority business plan.
- additional goals may be identified by health authorities to address unique priorities and community needs specific to a region or provincial program

## 8.7 Strategies

**Strategies** describe actions to be used to achieve goals and to address identified needs, issues and areas for improvement.

- provide high-level descriptions of short and long term actions to be used by health authorities to accomplish goals and to address identified needs, issues and areas identified for improvement
- findings from health needs assessments should be reflected in the strategies (reference: *Health Needs Assessment: A Guide for Regional Health Authorities*, Alberta Health and Wellness, to be published in 2000)
- all health authorities must develop strategies to achieve their goals, including general areas of strategy development such as:
  - ◊ collaborative initiatives with other regions, health providers or partners
  - ◊ major changes to programs and services to meet identified challenges
  - ◊ implications of known capital approvals and changes
  - ◊ initiatives carried over from previous years
  - ◊ an overview of the plans for each of the region's Community Health Council(s) for the coming year, including any plans to establish new community health councils, and any changes to the roles and functions of community health councils
- Business plans must include specific strategies that address the required areas for strategy development, which are identified in the following charts. These are generally linked to strategies in the Ministry of Health and Wellness business plan.

- required areas of strategy development for provincial health authorities may vary to reflect their specific areas of responsibility
- the year(s) the strategy is to be implemented should be identified

## 8.8 Performance Measures, Targets and Key Indicators

**Performance Measures** provide information on progress in achieving goals and are used to set priorities, adjust strategies, improve performance and increase public understanding of how well the health system is performing.

- performance measures and targets provide information about the achievement of goals
- performance measures results are used with other information to determine priorities, adjust strategies, analyze and improve performance and increase public understanding of how well the region and the health system are performing
- all performance measures identified in the business plan are to be included in the annual report to assess progress in achieving goals
- for each performance measure, the current level of performance and recent trends should be included in the business plan and annual report
- additional measures should be developed by health authorities to address specific priority areas
- each new goal developed by a health authority for its business plan should have at least one performance measure, and a performance target
- some performance measures will be developed jointly by Alberta Health and Wellness and health authorities over the course of the next year; health authorities may be asked to report results on these measures in their annual reports

**Required Performance Measures**

- performance measures identified in this document are required performance measures
- performance measures relate primarily to RHAs and must be included in all RHA plans for comparability of performance across the province
- performance measures may also be relevant for provincial health authorities, and if so, must be included in their plans
- some performance measures may apply only to highly specialized or province-wide services provided by a few health authorities, and must be included in their business plans

**Performance Measures Defined by Health Authorities**

- health authorities are required to develop at least one performance measure for each goal identified by the health authority. Health authorities may also develop additional performance measures
- performance measures defined by health authorities and included in their business plans must also have performance targets that indicate the year in which the target will be achieved

**Targets**

- health authorities are required to set a regional target for each performance measure identified in the business plan
- a target for a performance measure specifies the result to be achieved for the measure, and the target is stated using the same units as the measure (if the measure is "number of clients per 1,000 population" the target will be "X clients per 1,000 population); targets may in some cases be directional (increase, decrease) in relation to the current value for the measure
- targets specify the desired level of performance and identify the desired direction for change, typically improvement over the current state (e.g., increase immunization rate for MMR at 24 months to 98% by 2003)
- each target must specify a date (year), within the 3-year duration of the plan, by which the target is expected to be achieved
- provincial targets quantify the average level of achievement to be attained for Alberta; each health authority is expected to contribute to this achievement, usually by setting targets for improvement
- relevant data and supporting information should be used to set reasonable and feasible regional targets in relation to current performance; Alberta Health and Wellness may request additional supporting information to clarify the plan
- at least one regional target is required for each performance measure

**Key Indicators**

- health authorities may identify key indicators in their business plans
- key indicators are measures of important areas of health or health system activity which do not have provincial or regional targets identified
- results on key indicators may be used to reflect priorities, and strategies and increase public understanding of how the health system is performing
- key indicators are to be monitored, assessed and reported in the annual report
- health authorities may determine their own performance targets for key indicators

## Goal 1: To sustain and improve the delivery of accessible, effective, quality health services to Albertans who need them.

Objectives:

- to ensure reasonable **accessibility** to quality health services
- to continuously improve the **quality** of health services
- to improve the **continuity** of health services
- to ensure the **sustainability** of health services
- to encourage the **optimal contribution** of health **professionals**
- to support **quality living** for identified populations

| Required Areas of Strategy Development: | Key Performance Measures |
|---|---|
| • Develop a 10 year plan for Continuing Care, consistent with the policy decisions arising from the Long Term Care Review.<br>• Identify strategies to improve access to home care, develop partnerships for supportive housing options and reduce waiting lists for long term care.<br>• Evaluate service quality and accessibility for individuals with high health needs.<br>• Identify and implement innovations in service delivery, including integrated service delivery.<br>• Develop strategies to support community-based mental health services.<br>• Health authorities that deliver province-wide services should develop appropriate strategies, measures, and targets. | 1. Ratings of ease of access to health services*<br>2. Ratings of quality of service received, and effects of care on health*<br>3. Wait list for MRI, joint replacement, heart surgery and long-term care *<br>4. Alternative Level of Care (ALC) days/ efficiency in acute care facilities*<br>5. Community and home-based expenditure as a percent of total expenses, net of province-wide services.<br>6. Home care clients and direct service hours<br>7. Trends in acute care separations and average length of stay.<br>8. Percent MNRH (May Not Require Hospitalization)(Under Development)<br>9. Evaluations of service quality and access; selected programs and services |
| • Health Workforce Plan is developed, maintained and monitored (see Appendix V for format and requirements).<br>• Identify significant health workforce issues and develop plans and strategies for addressing issues.<br>• Develop human resource plans for each new business plan strategy predicted to have significant human resource impacts.<br>• Implement policy directions from the review of options for physiotherapy under the community rehabilitation program. | 10. Health Workforce measures are to be included as an attachment. |

## Goal 2: To improve the health and well-being of Albertans through health authority strategies for protection, promotion and prevention.

Objectives:

- to support and promote well-being and quality of life
- to protect health and well-being, and prevent disease and injury
- to enable Albertans to take responsibility for, and make informed decisions about their health and their use of health services
- to ensure cleaner air, water and food, and safer environments by working in partnership with others

| Required Areas of Strategy Development: | Key Performance Measures |
|---|---|
| • Update health promotion plans and evaluate initiatives<br>• Address high priority health issues, including low birth weight babies; childhood immunization; injuries; tobacco reduction; children's, seniors', and aboriginal health issues; breast cancer screening; and any other high priority health issues identified in the region<br>• Complete implementation of the enhanced pneumococcal vaccination program and planning for incorporation of other new vaccines for routine use in the Immunization Program.<br>• Implement the metabolic screening standards and guidelines<br>• Develop and implement an integrated, region-wide mechanism to address infection control in hospital and long term care settings<br>• Develop a plan to ensure a public health response capacity to respond to unpredictable and sporadic public health issues | 11. Percent low birth weight infants*<br>12. Mortality rates for injury and suicide*<br>13. Breast cancer screening rates*<br>14. Childhood immunization rates*<br>15. Population health measures: self-reported health, infant mortality, person years of life lost for major causes of death (PYLL).<br>16. Selected communicable disease rates<br>17. Changes in health status of selected populations identified by the health authority. |

## Goal 3: To support and promote a system for health

Objectives:

- to engage in collaborative planning with citizens and key stakeholders
- to ensure accountability throughout the health system
- to demonstrate leadership on emerging regional and system-wide challenges
- to encourage communication with and among stakeholders, including citizens
- to ensure the availability of timely, accurate and comprehensive information for population health, patient care, research and management of the system

| Required Areas of Strategy Development: | Key Performance Measures |
|---|---|
| • Develop a plan for health needs assessments and update strategies and actions to address findings<br>• Identify any plans to establish additional Community Health Councils.<br>• Identify any changes to the roles and functions of Community Health Councils.<br>• Provide an overview of the plans of the region's community health Council(s) for the coming year<br>• Collaborate with the Regional Child and Family Services Authorities, School Boards and other key stakeholders in the planning and delivery of services for children<br>• Collaborate with the Alberta Mental Health Board on the Alberta Children's Mental Health Initiative.<br>• Develop and implement a framework for community consultation<br>• Establish priorities for and outline strategies to evaluate the cost, impact and results of health authority programs and services | 18. Public self-rated knowledge of health services available *<br>19. Evidence that population health needs are assessed, and the results are used for priority setting.<br>20. Measures related to health and health service priorities are developed and reported. |
| • Implement continuous quality improvement strategies (e.g., accreditation, development of quality improvement plans), including those related to voluntary and private health service providers<br>• Develop implementation plans for Alberta we*ll*net and other information management and technology initiatives.<br>• Implement the *Health Information Act*. | 21. Evaluations of health impact, cost, and client satisfaction, for selected programs and services.<br>22. Percent of complaints where initial response is made within 3 working days |

## Goal 4: To optimize the effectiveness of the Health Authority

Objectives:

- to effectively manage available human, financial, and capital resources, including information and technology
- to foster the culture of a learning organization

| Required Areas of Strategy Development: | Key Performance Measures* |
|---|---|
| • Financial Plan is developed, maintained, and monitored.(See Appendices I to IV for format)<br><br>• Develop or update a long term capital plan for health authority infrastructure in 2000/01 (See Appendix VI for details).<br><br>• Implement self-assessment of board performance.<br><br>• Implement self-assessment of compliance with the 1998 Contracting Guidelines for Services. | 23. Balanced Budget:<br>• Annual Surplus/Deficit as a percentage of actual expenditure<br>• Percentage variance of actual expenditure to approved budget.<br>• Working Capital Ratio<br>• Average Remaining Useful Life of Capital Equipment<br><br>24. Long Term Capital Plan is submitted in 2000/01, including:<br>• Percentage of health authority infrastructure capacity utilized compared with target utilization rates.<br>• Number of partnership projects initiated in 2000-01.<br>• Percentage of health authority capital upgrading expenditures supported by the Integrated Health Facility Information System (IHFIS). |

*Note: Key Performance Measures marked with an asterisk are also performance measures in the Ministry business plan.

**Key Performance Measures** are listed in the charts that follow. Please refer to the Alberta Health and Wellness document *Information to Support Health Authority Business Plans and Annual Reports* on the Alberta Health and Wellness Website for further information related to the required measures.

Performance Measures marked with an asterisk (*) are measures that are also included in the Ministry business plan.

## Goal 1: To sustain and improve the delivery of accessible, effective, quality health services to Albertans who need them.

| 1. Ratings of ease of access to services.* | |
|---|---|
| **Description and Rationale** | This measure consists of public ratings of ease of access to needed services and indicates how well the health system is providing service, overall. These ratings can indicate whether the system as a whole is improving service access. |
| **Provincial Target** | Percent of Albertans who report access to health services is "easy" or "very easy".<br>Target (2002): 80%) |
| **Data and Method** | Information is produced from the annual Alberta Health and Wellness Survey. Data are responses to the following survey questions:<br>Access: "How easy or difficult is it for you to get the health care services you need when you need them? Would you say it is: very easy, easy, a bit difficult, very difficult?" |
| **Source** | Alberta Health & Wellness<br>Table G-3<br>A report of survey results is published, and regional data files are available on request. |
| **Annual Report** | Annual trends, and comparisons with the provincial average or the results from other appropriate regions, are to be reported.<br>The survey is conducted at the end of the fiscal year, and should be reported in the annual report for that fiscal year (that is, the 2000 survey results should be reported in the annual report for 1999-2000). |

| 2. Ratings of quality of service received and effects of care on health.* | |
|---|---|
| **Description and Rationale** | This measure consists of public ratings of quality of care personally received, and the proportion reporting that the effects of care on their health is excellent or good. These ratings can indicate whether the system as a whole is improving service quality. |
| **Provincial Target** | Percent who report that quality of care personally received is 'excellent' or 'good'.<br>Target (2003): 90%.<br>Percent who report that the effect of care on their health is 'excellent' or 'good'.<br>Target (2003): 85% |
| **Data and Method** | Information is produced from the annual Alberta Health and Wellness Survey. Data are responses to the following survey questions:<br>Quality: [asked only of those who reported receiving services in the past 12 months] "Overall, how would you rate the quality of care you personally have received in the past 12 months? Would you say it was: excellent, good, fair, poor?" |
| **Source** | Alberta Health & Wellness<br>Table G-2a,2b<br>A report of survey results is published, and regional data files are available on request. |
| **Annual Report** | Annual trends, and comparisons with the provincial average or the results from other appropriate regions, are to be reported.<br>The survey is conducted at the end of the fiscal year, and should be reported in the annual report for that fiscal year (that is, the 2000 survey results should be reported in the annual report for 1999-2000). |

| 3. Wait list and number of persons served for MRI, joint replacement, heart surgery and long term care.* | |
|---|---|
| **Description and Rationale** | This measure shows the number of persons waiting and the number of persons served during each quarter for: MRI diagnostic tests, joint replacement, heart surgery, and long term care. |
| **Provincial Target** | Target 2002-03 – Decreasing trends in the number of persons on waiting lists. |
| **Data and Method** | Quarterly reporting by regional health authorities has begun, and data definitions and methods for reporting will be determined through this process. |
| **Source** | Alberta Health and Wellness, and regional health authorities |
| **Annual Report** | Regional health authorities with responsibilities for delivering these services will report the number of persons served and the number waiting at the end of each quarter. Average (mean) and median wait times may also be reported. |

| 4. Alternative level of care (ALC) days as a percent of total patient-days in acute care.* | |
|---|---|
| **Description and Rationale** | This measure shows the percent of total hospital days that could have been provided in an alternative setting, as determined by medical staff. A suitable alternative setting would most often be continuing care or palliative care. Percent ALC days is an indicator of the efficient use of hospital facilities, and also indicates the level of need within the region for alternative care services and current access to these services. |
| **Provincial Target** | Target 2002-03: Decreasing trend in ALC days as a percent of total days.<br>Health authorities must determine their own targets, taking into consideration current performance, client needs, and alternatives for care. |
| **Data and Method** | Data are obtained from the Hospital Morbidity File. The decision about whether a patient requires an alternate level of care is made by the patient's physician. ALC days are counted from the date on which this decision is made. |
| **Source** | Alberta Health & Wellness<br>Table F-12 |
| **Annual Report** | Annual trends are to be reported in the Annual Report, along with the provincial average or the results from other appropriate regions for comparison. These results might be presented along with relevant long term care statistics. |

| 5. Community and home-based expenditure as a percent of total expenses, net of province-wide services. | |
|---|---|
| **Description and Rationale** | This measure shows the extent to which health services are increasingly delivered in home and community settings. Funding for province-wide services (in Calgary and Capital health regions) are excluded from the calculation. |
| **Provincial Target** | Increase in expenditure as a percentage of total expenditure, as compared with previous year. |
| **Data and Method** | Definitions for community and home based expenditure are found in FD13. The measure to be reported is community and home-based expenditure as a percentage of total expenditure (province-wide services funding is removed from total expenditure for Calgary and Capital regions). |
| **Source** | Health authority financial statements.<br>Comparative information is available in the Ministry annual reports. |
| **Annual Report** | This measure is to be reported as a trend over several years (from 1994/95).<br>It may be reported within the context of expenditure trends for other services to provide a more complete indication of how resources are allocated. |

| 6. Home care clients and direct service hours by type of care per 1,000 population by age category. | |
|---|---|
| **Description and Rationale** | This measure reports on the provision of health services in the home (per 1,000 population), in three care categories: short term, long term and palliative care. The health system continues to find ways to deliver needed health services in community and home settings in order to achieve best value, and to relieve pressure on facility based care. |
| **Provincial Target** | Increasing use of home-based service alternatives to facility based care. |
| **Data and Method** | Data are provided by Alberta Health and Wellness from the Home Care Information System, using standard reports. Rates per 1,000 population for different age categories are based upon the Alberta Health Care Insurance Plan registration file. |
| **Source** | Alberta Health & Wellness<br>Tables D-1 to D-10; D-12 may also be useful |
| **Annual Report** | Results, showing annual trends, are to be included in the Annual Report, along with comparisons with the provincial average or the results from other appropriate regions. Results should be presented along with other measures of service delivery to show how health service needs are being met in community settings. |

| 7. Trends in acute care separations and average length of stay. | |
|---|---|
| **Description and Rationale** | These measures show the acute care hospitalization average length of stay (ALOS) by region of service, and the hospital separation rate (per 1,000) by region of residence. Trends in ALOS and hospital separation rates may indicate more or less efficient use of acute care facilities, which may be related in part to the availability in the community of alternatives to facility based care. Results may be analyzed and discussed in relation to region of residence or region of service, or both, depending upon the specific needs, goals and targets identified in the health authority plan. Hospital separation rate (by region of residence) may also be used to indicate the level of health service needs of region residents. |
| **Provincial Target** | Maintain or improve current performance.<br>Health authorities must determine their own targets, taking into consideration current performance, client needs, import/export patterns, and alternatives for care. |
| **Data and Method** | Data for acute care separations and total days stay are obtained from Health Records for in-patient activity. Population estimates are from AHCIP registration file. Average length of stay is calculated for all separations with total days stay less than one year; acute care patients with longer stays are excluded. Data are provided by Alberta Health and Wellness, through CIHI. |
| **Source** | Alberta Health & Wellness<br>Tables F-2a; F-5a<br>Information in Tables F-1; F-2b; F-3; F-4a; F-4b; F-5b may also be useful. |
| **Annual Report** | Annual trends for ALOS and hospital separation rates are to be reported and discussed in the Annual Report, along with results from other appropriate regions for comparison. Reporting these trends along with trends in community and home based service delivery could show progress toward goals related to the effective use of resources. |

| 8. Percent MNRH (May Not Require Hospitalization) (under development). | |
|---|---|
| **Description and Rationale** | This measure shows the extent to which acute care in-patient facilities are used for services that could be provided appropriately in some other setting (for example, out-patient or community clinic, home care, physician office). The measure is directly related to the efficient use of acute care facilities, but also reflects the availability and use of appropriate alternatives. |
| **Provincial Target** | Maintain or improve current performance.<br>Health authorities must determine their own targets, taking into consideration current performance client needs, and alternatives for providing appropriate care. |
| **Data and Method** | Data are prepared from the Hospital Morbidity File. The criteria for MNRH are defined by CIHI and determined by the case mix group (CMG) for each record. |
| **Source** | Alberta Health & Wellness<br>Table F-11 |
| **Annual Report** | Annual trends for MNRH rates (percent of all hospital separations) are to be reported in the Annual Report, along with provincial averages or the results from other appropriate regions for comparison. |

| 9. Service quality and access ratings by selected population with specific needs and targeted for improvement by the Health Authority. | |
|---|---|
| **Description and Rationale** | This measure requires that an evaluation be conducted to obtain feedback from a subset of the population. The population for study should be selected by the health authority because of some special concerns about access or quality of service. Some examples of special populations are: seniors, isolated communities, persons with disabilities or chronic illness, new mothers and their infants, and so on. |
| **Provincial Target** | Improved service quality and/or access: to be determined by each health authority. |
| **Data and Method** | Evidence consists of a written report of the evaluation conducted by the health authority, including a description of method, the results and a discussion of findings. |
| **Source** | Health authority |
| **Annual Report** | The key results are to be reported in the Annual Report. It is requested that the name and address of a contact person familiar with the evaluation be included. |

| 10. Health Workforce Measures - See Appendix V for details: | |
|---|---|
| **Description and Rationale** | Health authorities are expected to develop a health workforce plan including strategies to address significant health workforce issues in their region, and human resource plans for each new business plan strategy predicted to have significant human resource impacts. The health workforce plan should be an attachment to the business plan. |
| **Regional Target** | None required this year. |
| **Data and Method** | The health workforce measures in Appendix V were developed by the Provincial Health Workforce Steering Committee. Regional Health Workforce data should be presented in an attachment or appendix using the data in the templates in Appendix V. |
| **Source** | Health authority |
| **Annual Report** | Health Authorities must report on the results or progress of health workforce strategies completed or underway in their annual reports. |

## Goal 2: To improve the health and well-being of Albertans through health authority strategies for protection, promotion and prevention.

| 11. Percent low birth weight infants* | |
|---|---|
| **Description and Rationale** | The percent of low birth weight (<2500grm) newborns is an indicator of the overall population health status. It is influenced by many factors including biological, physical, and social factors and access to health services. |
| **Provincial Target** | Target 2002: Percent of newborns with birth weight less than 2500 grams - at most 5.5% of live births.<br>Health authorities should set their own targets. |
| **Data and Method** | Low birth weight: Live births with birth weight under 2500 grams, as a percent of the total live births. Health authority is determined by the mother's residence, not by the place of birth of her infant. Data are derived from Alberta Vital Statistics. |
| **Source** | Alberta Health & Wellness<br>Table B-3a |
| **Annual Report** | Trends, along with comparisons with the provincial average or the results from other appropriate regions, are to be reported. |
| **Notes** | For some regions, several years of data should be combined in order to produce sufficiently reliable information for smaller populations. |

| 12. Mortality rates for injury and suicide* | |
|---|---|
| **Description and Rationale** | Standardized mortality rates (SMRs) are rates of death standardized for age and gender. They are the rates that would occur if each region had the same population structure (by age and gender) and their own rate of death for each major cause. Standardization allows comparisons among regions. Lower rates indicate improvement in the prevention, detection and treatment of these major causes of death. |
| **Provincial Target** | Targets 2002: 45 per 100,000 for deaths due to injury<br>(including suicide, homicide and injury).<br>13 per 100,000 for deaths due to suicide. |
| **Data and Method** | Rates are calculated from death statistics reported by Alberta Vital Statistics and population estimates based the Registry File for the Alberta Health Care Insurance Plan (AHCIP). Rates are calculated and provided by Alberta Health and Wellness. |
| **Source** | Alberta Health & Wellness<br>Table B-5b |
| **Annual Report** | Trends are to be reported in the Annual Report, along with provincial averages or the results from other appropriate regions for comparison. |

| 13. Breast cancer screening rates.* | |
|---|---|
| **Description and Rationale** | Mammography screening for breast cancer is recommended every 2 years for women 50-69. |
| **Provincial Target** | Target 2002-03: 75% of women aged 50-69 have mammography screening for breast cancer every two years. |
| **Data and Method** | The Alberta Population Health Survey (1996/97) provided regional estimates for breast cancer screening rates. A new method for calculating this measure will be developed in conjunction with improved information systems. |
| **Source** | Alberta Health & Wellness<br>Table 23 A-D from Selected Tabulations from the National Population Health Survey (1996-97), Health Surveillance Branch, April 1999. |
| **Annual Report** | Breast cancer screening rates are to be reported in the Annual Report. |

| 14. Childhood immunization coverage.* | |
|---|---|
| **Description and Rationale** | This measure is the percent of the population of 2 year olds who have been appropriately immunized, according to Alberta standard:<br>• At 12 months: 3 doses DPT (diphtheria, pertussis, tetanus), 3 doses PRPT (Hib – haemophilus influenza type b), 2 doses IPV (polio);<br>• At 24 months: 1 dose of MMR (measles, mumps, rubella), a fourth dose of DPT, PRPT (Hib) and IPV. |
| **Provincial Target** | Target 2002: DPT, PRPT, IPV - at least 97% of 2 year olds immunized to standard.<br>Target 2002: MMR - at least 98% of 2 year olds immunized to standard. |
| **Data and Method** | Immunization rates are calculated for the calendar year. Rates are based upon immunization statistics and population estimates derived from AHCIP Registry files. |
| **Source** | Alberta Health & Wellness<br>Table B-12 |
| **Annual Report** | Coverage rates are to be reported for DPT, PRPT (Hib), IVP and MMR. The provincial coverage rate should be reported for comparison. |

| 15. Population health measures: trends and comparison with best region and provincial performance. | |
|---|---|
| **Description and Rationale** | The following measures are included: self-reported health status, infant mortality, and potential years of life lost (PYLL) for major causes of death. This set of measures is used to indicate the health of the population. Health authorities may have specific priorities and strategies related to any of these measures, or any other aspect of health. |
| **Provincial Target** | Self-reported health: at least 70% (age 18-64) report excellent or very good health.<br>Infant mortality: at most 5.0 per 1,000.<br>PYLL for major causes: to be determined by health authority.<br>Health authorities should set their own targets. |
| **Data and Method** | Self-reported health: Data are from the Alberta Health and Wellness Survey and are responses to the question: "In general, compared with other persons your age, would you say your health is: excellent, very good, good, fair, poor?"<br>Infant mortality: Number of infants (under 1 year old) who die within the calendar year (multiplied by 1,000), divided by the number of live births during that same year. Health authority determined by place of residence. Data are derived from Alberta Vital Statistics.<br>Potential years life lost (PYLL): For all deaths at age less than 75, PYLL is the sum of the difference, in years, between 75 and the age at death. PYLL is expressed as a ratio of total years lost per 100,000 population, for males and females separately, for major causes of death. Data are derived from Alberta Vital Statistics. |
| **Source** | Alberta Health & Wellness<br>Table G-16; Table B-2a; Table B-4 |
| **Annual Report** | Trends, along with comparisons with the provincial average or the results from other appropriate regions, are to be reported. |
| **Notes** | For some regions, several years of data should be combined in order to produce sufficiently reliable information for smaller populations. |

| 16 Selected communicable disease rates. | |
|---|---|
| **Description and Rationale** | This measure selects specific diseases that represent programs in childhood immunization, food and water quality, and tuberculosis. |
| **Provincial Target** | Provincial targets have been set at no more than the following number of cases per 100,000 population: E. Coli Colitis: 4.0; Pertussis: 18.0; Tuberculosis: 4.5; Measles: 0; Polio: 0. |
| **Data and Method** | Notifiable diseases are reported to the Provincial Health Officer, who provides an annual summary (calendar year) of new cases in March of each year. Rates will be calculated based upon population estimates from the AHCIP registration file. |
| **Source** | Alberta Health & Wellness<br>Tables B-6 and B-7 |
| **Annual Report** | Both the number of new cases and the calculated rate per 100,000 population are to be reported in the Annual Report. The provincial rate and the provincial target should be reported for comparison. Due to the small numbers of cases for some diseases, regional reporting should consider using 3-year rolling averages. |

| 17. Change in health status of selected populations identified by the health authority. | |
|---|---|
| **Description and Rationale** | This measure requires that the health needs and health status of selected populations, identified by the health authority as a priority for improved health status, be evaluated, to show whether improved health outcomes are being achieved. |
| **Regional Target** | Improved health status of selected group: to be determined by each health authority. |
| **Data and Method** | Evidence consists of a written report of the evaluation conducted by the health authority, including description of method, the results and a discussion of the findings. |
| **Source** | Health authority |
| **Annual Report** | Key results are to be reported in the Annual Report. It is requested that the name and address of a contact person familiar with the evaluation be included. |
| **Notes** | Smaller adjoining regions may find it practical to work together on a project of mutual concern. Health authorities are encouraged to advise each other of their projects, to facilitate collaboration and avoid unnecessary duplication. |

## Goal 3: To support and promote a system for health

| 18. Public self-rated knowledge of health services available. | |
|---|---|
| **Description and Rationale** | This measure consists of public self-assessment of their knowledge of health services and the health system. Improved knowledge of available health services should be related directly to easier access. Changes in self-rated knowledge can indicate how well the public is informed of services available to them. |
| **Provincial Target** | Target 2003: At least 75% of Albertans rate their knowledge of available services as good or excellent. |
| **Data and Method** | Information is produced from the Alberta Health and Wellness Survey, conducted annually. Data are responses to the following question: "In general, how would you rate your knowledge of the health services that are available to you? Excellent, good, fair or poor?" |
| **Source** | Alberta Health & Wellness<br>Table G-5<br>A report of survey results is published, and regional data files are available on request. |
| **Annual Report** | Annual trends and comparisons with provincial average are to be reported. Results may be reported in the context of local strategies to improve knowledge of available services. |

| 19. Evidence that population health needs are assessed, and the results are used for priority setting and planning. | |
|---|---|
| **Description and Rationale** | Health needs assessment is a process that includes analysis of existing and new information that describes the health and the health needs of the health authority's population, including mental health needs. The assessment should be updated continuously, as new information becomes available. It provides facts on which decisions about programs, services and resource allocation can be based. It is a basic tool for setting priorities and planning for the health authority. |
| **Regional Target** | A plan should be developed and updated annually, for obtaining health needs assessment information and using the results. |
| **Data and Method** | Evidence consists of documentation on the methods used and the findings of the assessment of population health needs, including information developed as part of the assessment. |
| **Source** | Health Authority<br>Information to support regional health needs assessments is available in various reports prepared by Alberta Health & Wellness and other sources. |
| **Annual Report** | Quote key findings from health needs assessments, and identify priorities, and actions determined by the Region, based on the health needs assessments. |

| 20. Measures related to health and health service priorities are developed and reported. | |
|---|---|
| **Description and Rationale** | Health priorities and health service priorities are determined by the board, based on the results of health needs assessments and other evidence. The health authority should develop and report on measures that will show whether priority needs are being addressed successfully. |
| **Regional Target** | A measure and performance target should be developed for each of these priorities. |
| **Data and Method** | Determined by the health authority |
| **Source** | Health authority<br>Relevant information may be available from the Ministry for some priority areas. |
| **Annual Report** | Priorities should be identified and results included in the report. |

| 21. Evaluations of health impact, cost, and client satisfaction for selected programs and services. | |
|---|---|
| **Description and Rationale** | Health authorities are required to assess and evaluate their programs and services in terms of results such as costs, health outcomes and client satisfaction. Evaluations support the identification of opportunities to improve services and program delivery. Health authorities should develop a plan to evaluate programs and services that are of particular interest to them, and are to report on the results of the evaluation. Results from the evaluation should support better decisions and continuous improvement in the delivery of health services. |
| **Regional Target** | At least one program or service should be evaluated each year. |
| **Data and Method** | Evidence consists of a written report of the evaluation, including a description of the method and results, and a discussion of the findings. When projects extend over a number of years, interim or preliminary findings may be reported. |
| **Source** | Health authority |
| **Annual Report** | Key results should be incorporated into the Annual Report. It is requested that the name and address of a contact person familiar with the evaluation be included. |
| **Notes** | Smaller adjoining regions may wish to work together on an evaluation of a program or service of mutual interest. Health authorities are encouraged to advise each other of their evaluation plans, to facilitate collaboration and avoid unnecessary duplication. |

| 22. Percent of complaints where initial response is made within 3 working days. | |
|---|---|
| **Description and Rationale** | Health authorities are required to have a process for addressing concerns and complaints about services. This measure monitors and reports on the percent of complaints that receive an initial response from the health authority within two working days. This initial response may simply be an acknowledgement that the concern has been received and will be addressed. |
| **Regional Target** | Percent of complaints receiving a response within 3 working days; to be determined by the health authority. |
| **Data and Method** | Developed by the health authority |
| **Source** | Health authority |
| **Annual Report** | Results on this measure may be included as part of a more detailed description of the concerns resolution process for the health authority. |

## Goal 4: To optimize the effectiveness of the Health Authority

| **23. Balanced budget - See Appendices I to IV for details on the following:**<br>• Annual Surplus/Deficit as a percentage of actual expenditure<br>• Percentage variance of actual expenditure to approved budget<br>• Working Capital Ratio<br>• Average remaining useful life of Capital Equipment. | |
|---|---|
| **Description and Rationale** | Health authorities are expected to submit a balanced budget (a budget is balanced when revenues equal expenses). In the event that a health authority does not plan to have a balanced budget, it must submit a deficit elimination plan. |
| **Regional Target** | A health region must deliver planned health services within available resources. Actual expenditures should be less than or equal to available resources. |
| **Data and Method** | Budgets and financial statements developed in accordance with the most recent Financial Directive and business plan requirements. |
| **Source** | Health authority |
| **Annual Report** | Financial results should be discussed in the "Management Discussion and Analysis" section of the Annual Report. |

| **24. Current Long Term Capital Plan is submitted in 2000/01, including all required elements. (See Appendix VI for details)** | |
|---|---|
| **Description and Rationale** | Health authorities are required to submit a long-term capital plan that reflects projected program and service needs to the Minister of Health and Wellness by the end of the 2000-01 fiscal year. The plan will prioritize capital needs for the next three years or longer. Alberta Health and Wellness, Infrastructure, and Health Authorities will define elements of a long-term capital plan, and targets for utilization, partnerships, and information system use.<br><br>The Long Term Capital Plan should:<br>• Be based on projected program and service needs,<br>• Include the divestiture and alternate use of existing facilities,<br>• Seek innovative, cost-effective partnership arrangements for meeting infrastructure needs, and<br>• Include plans to utilize the Integrated Health Facility Information System (IHFIS) to support capital upgrading. |
| **Regional Target** | Long Term Capital Plan is approved, and targets for capacity utilization, number of partnership arrangements proposed, and information system use are achieved. |
| **Data and Method** | Evidence that the health authority long term capital plan is submitted in 2000/01, including:<br>• Compliance with reporting requirements,<br>• Percentage of health authority infrastructure capacity utilized, compared with target utilization rates.<br>• Number of partnership projects identified in capital plan.<br>• Percentage of health authority capital upgrading expenditures supported by the Integrated Health Facility Information System (IHFIS), in compliance with reporting requirements. |
| **Source** | Health Authority |
| **Annual Report** | Include in section titled "Long Term Capital Plan". |

## 8.9 Long Term Capital Plan

- An important business planning consideration for health authorities is to identify capital infrastructure needed to deliver programs and services. Provide a brief overview of the health authority's long term capital plan, or the strategy for developing and updating it, and confirm that the Authority's long term capital plan will be submitted in 2000/01.

**Approved Capital Projects** should be identified in the business plan.

### Approved Capital Projects

- Funds provided by Infrastructure relating to items of a capital nature, such as facility construction, should be identified in the statement of changes in financial situation as well as in the narrative part of the plan.
- Operating costs related to approved capital projects scheduled for completion within the Business Plan period must also be identified in the narrative.

**Proposed projects** are included only as information in the narrative of the financial section to assist in reviewing and understanding the plan; a separate approval process for proposed projects is outlined in the Capital Planning Manual.

### Proposed Capital Projects

- The approval process for proposed projects is outlined in the guide to the approval process for health capital projects, Capital Planning Manual.
- Identify only those major capital projects proposed for implementation within the business plan period, indicating priorities and associated future operating costs.
- Proposed projects approved during the year can be incorporated into the financial plan at that time.

## 8.10 Information Management, we//net, and technology

**Executive Summary of the Information Management, we//net, and technology action plan** is to be included as an appendix to the business plan.

An executive summary of the health authority's Information Management, we//net, and technology action plan is to be included as an appendix to the business plan. This requirement does not replace the existing reporting process established by Alberta Health and Wellness. The financial information relating to Information Management should be included in the financial component of the plan. Where Information Management costs are included as part of the administration costs these should be appropriately identified to facilitate review and analysis of the business plan.

## 8.11 Financial Information

### Purpose

- To communicate the anticipated effects on resources of a health authority in carrying out the proposed business plan strategies.
- Health authorities are expected to submit a balanced budget. A budget is balanced when revenues equal expenses. Revenues and expenses are to be determined in accordance with Generally Accepted Accounting Principles (GAAP)

A **balanced budget** is to be submitted

### Financial Plan

- Must be included in the business plan in the format provided in appendices I, II and III. These appendices are intended to mirror the requirements of Financial Directive 16 currently under development and due to be issued on January 31, 2000.
- At a minimum, must include:
  - Statement of Operations - explanation of changes in specific revenue and expense categories should be linked to the strategies identified in the narrative, where appropriate
  - Statement of Financial Position (Balance Sheet),
  - Statement of Cash Flows;
  - Capital Equipment Plan; and
  - Summary of Debt Level.
- Additional information may be submitted separately to amplify the financial plan such as reconciliation of Alberta Health and Wellness and other government contributions, and list of approved Alberta Infrastructure capital projects, and their operating impacts.
- Use the most recent information provided on funding targets.
- Use current rates for Alberta Health and Wellness approved fees and charges.
- Include only 50% of Out-of-Country Surcharge revenue in fees and charges.
- Historical and other available information should be used as a context to provide value added information for assessment of the plan.

**Financial Plan**, at a minimum, includes:

- Statement of Operations
- Statement of Financial Position
- Statement of Cash Flows
- Capital Equipment Plan
- Summary of Debt Level

### Deficit and Surplus

- A health authority is expected to submit a deficit elimination plan relating to accumulated deficit.

- "accumulated deficit" is defined as a negative amount when summing unrestricted net assets and internally restricted net assets at the end of the fiscal year
- "accumulated surplus" is defined as a positive amount when summing unrestricted net assets and internally restricted net assets at the end of the fiscal year

**Temporary Deficits**

Alberta Health and Wellness will recommend to the Minister acceptance of a business plan that projects a temporary deficit if:

- A health authority submits a business case rationale for the one-time cost that caused the deficit.
- An analysis of future cost-savings as a result of the one-time cost, including the basis and assumptions used.
- The deficit payback period is reasonable, and
- Deficit financing, if any, does not result in the borrowing limits prescribed by the Minister to be exceeded.

**Capital Equipment Plan**

- An important business planning consideration for health authorities is to identify capital equipment needed to deliver programs and services. Health authorities are therefore expected to formally set aside cash amounting to, a minimum of the annual internally funded equipment amortization not reinvested in capital equipment.
- Health authorities may also wish to finance capital equipment acquisitions from short and long-term borrowings including capital leases, within their borrowing by-laws.
- The capital equipment template provided in Appendix IV is designed to assist health authorities summarize their capital equipment needs. As a minimum, the Plan shall identify the proposed strategies to replace internally and externally funded capital equipment, including those at contracted facilities for which the health authority has primary responsibility.
- The Plan shall provide the basis and assumptions used, risk factors that can hinder the planned replacement, sources of funds, and other relevant information to enable Alberta Health and Wellness to assess the plan.
- The Capital Equipment Plan shall be signed by the health authority's Chief Executive Office and Chief Financial Officer signifying management's commitment to achieve the results indicated in the Plan

**Summary of Debt Level**

- a health authority shall not exceed its debt limit indicated in its borrowing by-laws
- indicate new debt planned during the plan period
- indicate how the health authority plan to retire its total debt and the time frame for retirement
- "total debt" is defined as the sum of bank indebtedness plus the amount of long-term debt and capital lease obligations at the end of the plan period

### 8.12 Health Workforce Plan

The Health Workforce Plan should be included as an attachment or appendix to the business plan. See Appendix V for details.

## 9. Health Authority Annual Reports

**Elements of Health Authority Annual Reports**

- Letter of Accountability
- Board Governance
- Organizational and Advisory Structure
- Major Initiatives/Accomplishments
- Contextual Information for Results Achieved
- Progress and Results
- Challenges and Future Directions
- Long Term Capital Plan
- Financial Summary
- Health Workforce Plan Progress

The principal function of the annual report is to report to the Minister on the activities, performance and achievements of the health authority concerning its legislated responsibilities and other responsibilities delegated to the authority by the Minister. The health authority annual report is a public accountability document submitted to the Minister of Health. As such, it reports on key areas fundamental to good accountability: governance and organization, services, and financial results. It highlights the accomplishments, progress and results achieved over the year, and explains any significant variation between planned performance and actual performance. The annual report is based on the health authority business plan for the first fiscal year of the three-year planning cycle; for example, the health authority annual report for 1999-2000 is based on the health authority business plan for 1999-2000 to 2001-2002.

Reporting results achieved is an important part of the accountability cycle. The annual report also includes an analysis of results that identifies areas of strong performance and those needing improvement. The areas requiring improvement should be addressed in subsequent business plans. The following elements are to be included in health authority annual reports for 1999-2000 and 2000-2001:

**Required Letter of Accountability**
We have the honor to present the annual report for the _____ Health Authority, for the fiscal year ended March 31, ____.

This annual report was prepared under the Board's direction, in accordance with the *Government Accountability Act, Regional Health Authorities Act* and directions provided by the Minister of Health. All material economic and fiscal implications known as at July 31, ___ have been considered in preparing the annual report.

Respectfully Submitted on Behalf of
_____ Health Authority,

Signed by Health Authority Chair

## 9.1 Letter of Accountability from the Health Authority Chair

- confirms the annual report was developed in accordance with appropriate legislative authority and government requirements
- must be incorporated into the report, using the wording specified
- indicates that the Board has approved the report

## 9.2 Board Governance

Briefly describes:

- the primary roles and responsibilities of the Board
- the important activities and decisions of the Board
- the relationship between the Board and senior management
- major consultations with the public and other stakeholders
- how the board assures itself that the business plan is implemented, that funds are allocated appropriately, and that effective systems of control and legislative compliance are maintained
- the methods used to maintain board transparency
- how the board addresses risk management
- the process for self assessment of board performance

## 9.3 Organizational and Advisory Structure

- describes the current organizational and advisory structure
- identifies changes to the organizational and advisory structure that occurred during the year
- includes an overview of the Community Health Councils: names, dates established, mandate, accomplishments
- includes names telephone number, address or e-mail by which the public can contact the health authority board and senior management

## 9.4 Major Initiatives/Accomplishments

- Briefly highlights and summarizes major initiatives and accomplishments in the implementation of the business plan over the last year.

### 9.5 Contextual Information for Results Achieved

- provides a description of the relevant geographical, social and economic environment in which results were achieved
- includes, but is not limited to, pertinent findings from community needs assessments and information about health authority resources (both people and facilities), and factors affecting the health of the population of the region
- identifies key health authority priorities for the year, as determined by the board and stated in the plan
- may include health status indicators such as life expectancy and information on health determinants such as education levels or poverty

### 9.6 Progress and Results

- includes all the goals and strategies from the health authority business plan and reports, in narrative form, progress in implementing the strategies
- the relevant performance measures and results integrates into the report on progress; they are not to be reported separately from the goals and strategies
- includes information about the performance measures identified in the business plan for each goal, along with any supporting information that can help explain the results
- includes the performance target and recent trend information along with the performance measure results
- compares results achieved to the target; indicates for each performance measure where results are satisfactory or exceed expectations and identifies areas for improvements to be addressed in the next plan
- provides an analysis and explanation for differences between achievements and targets established for business plan goals
- includes other relevant information to support explanation and analysis of results, progress, challenges and future directions as appropriate
- may compare regional results with provincial results and provincial performance targets, or with comparable regions or organizations
- links the analysis of results to the contextual information for explanation of key results
- clearly identifies information sources

### 9.7 Challenges and Future Directions

- are determined from the analysis of results presented in the previous section of the report
- are based on facts already presented in the report; for example, as contextual information, progress on strategies, results achieved, or performance targets not achieved
- identifies areas to be addressed in the next planning cycle

### 9.8 Long Term Capital Plan

- Provides a brief overview of progress on the health authority's long term capital plan.

### 9.9 Financial Summary

- The Annual Report shall include the following:
  - An audited financial statement
  - A Statement of Management Responsibility for Financial Reporting, as discussed in FD-16.
  - Management Discussion and Analysis (MD&A). A guideline on its content will be provided by January 31, 2000.
  - Explanation of any line item variance between budget and actual amounts of greater than 10%. Any additional information that can improve the communication value of the annual report may be provided.
  - Key Financial Indicators (KFI) on a three-year trend for the items described below. The methodology of calculation will be provided by January 31, 2000 to ensure consistency in reporting across the health regions.
    - Ratio of Administration Cost
    - Adjusted Working Capital Ratio
    - Import/Export Funding Adjustment Ratio
    - AH Funding Coverage Ratio
    - Remaining Useful Life of Capital Equipment
    - Borrowing Accessed Ratio
    - Distribution of Expense Ratio

### 9.10 Health Workforce Plan Progress

- Health Authorities must report on the results or progress of health workforce strategies completed or underway in their annual reports. See Appendix V for details.

**HEALTH AUTHORITY BUSINESS PLAN**

**FINANCIAL PLAN TEMPLATE-I**

**REGION:**

## 2000-2001 HEALTH AUTHORITY BUDGET ESTIMATES

**(thousands of dollars)**

**SECTION A – STATEMENT OF OPERATIONS**

| | 1998-99 ACTUAL $ | 1999-00 FORECAST $ | 2000-2001 BUDGET $ | 2001-2002 BUDGET $ | NOTE REFERENCE TO EXPLAIN CHANGES |
|---|---|---|---|---|---|
| **REVENUE** | | | | | |
| Alberta Health and Wellness Contributions | X | X | X | X | |
| Other Government Contributions | X | X | X | X | |
| Fees and Charges | X | X | X | X | |
| Net Ancillary Operations | X | X | X | X | |
| Donations | X | X | X | X | |
| Investment and Other Income | X | X | X | X | |
| Amortization of External Capital Contributions | X | X | X | X | |
| **TOTAL REVENUE** | 0 | 0 | 0 | 0 | |
| **EXPENSES** | | | | | |
| Facility Based Inpatient Acute Services | X | X | X | X | |
| Facility Based Emergency and Outpatient Services | X | X | X | X | |
| Facility Based Continuing Care Services | X | X | X | X | |
| Community & Home Based Services | X | X | X | X | |
| Diagnostic & Therapeutic Services | X | X | X | X | |
| Promotion, Prevention and Protection Services | X | X | X | X | |
| Research & Education | X | X | X | X | |
| Administration | X | X | X | X | |
| Information Technology and we//net | X | X | X | X | |
| Y2K Remedial costs | X | X | X | X | |
| Support Services | X | X | X | X | |
| Amortization of Facilities and Improvements | X | X | X | X | |
| Capital Assets Write Down | X | X | X | X | |
| **TOTAL EXPENSES** | 0 | 0 | 0 | 0 | |
| **Excess(deficiency) of revenues over expenses** | 0 | 0 | 0 | 0 | |

**X Indicates Information required if applicable**

**HEALTH AUTHORITY BUSINESS PLAN**

**FINANCIAL PLAN TEMPLATE II**

**REGION:**

**SECTION B - STATEMENT OF FINANCIAL POSITION**

**STATEMENT OF FINANCIAL POSITION**
**(thousands of dollars)**

| | 1998-99 ACTUAL $ | 1999-00 FORECAST $ | 2000-2001 BUDGET $ | 2001-2002 BUDGET $ |
|---|---|---|---|---|
| **ASSETS** | | | | |
| Current: | | | | |
| Cash and temporary investments | X | X | X | X |
| Accounts receivable | X | X | X | X |
| Contributions receivable | X | X | X | X |
| Inventories | X | X | X | X |
| Prepaid expenses | X | X | X | X |
| | 0 | 0 | 0 | 0 |
| Non-current cash and investments | X | X | X | X |
| Capital assets | X | X | X | X |
| Other assets | X | X | X | X |
| | 0 | 0 | 0 | 0 |
| **LIABILITIES AND NET ASSETS** | | | | |
| Current: | | | | |
| Bank indebtedness | X | X | X | X |
| Accounts payable | X | X | X | X |
| Accrued vacation pay | X | X | X | X |
| Deferred contributions | X | X | X | X |
| Current portion of long-term debt | X | X | X | X |
| | 0 | 0 | 0 | 0 |
| Deferred contributions | X | X | X | X |
| Deferred capital contributions | X | X | X | X |
| Long-term debt | X | X | X | X |
| Pension plan obligation | X | X | X | X |
| Unamortized external capital contributions | X | X | X | X |
| Other liabilities | X | X | X | X |
| | 0 | 0 | 0 | 0 |
| Net assets: | | | | |
| Unrestricted | X | X | X | X |
| Internally restricted | X | X | X | X |
| Investment in capital assets | X | X | X | X |
| Operating net assets | 0 | 0 | 0 | 0 |
| Endowments | X | X | X | X |
| | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 |

**X Indicates Information required if applicable**

HEALTH AUTHORITY BUSINESS PLAN
FINANCIAL PLAN TEMPLATE- III
REGION:
SECTION C – STATEMENT OF CASH FLOWS

Appendix III

STATEMENT OF CASH FLOWS
(thousands of dollars)

| | 1998-99 ACTUAL $ | 1999-00 FORECAST $ | 2000-2001 BUDGET $ | 2001-2002 BUDGET $ |
|---|---|---|---|---|
| **Cash generated from (used by):** | | | | |
| **Operating activities** | | | | |
| Excess (deficiency) of revenues over expenses | x | x | x | X |
| Non-cash transactions: | | | | |
| Decrease in unfunded pension obligations | x | x | x | X |
| Amortization of capital equipment - internally funded | x | x | x | X |
| - externally funded | x | x | x | X |
| Amortization of facilities & improvements | x | x | x | X |
| Amortization of external capital contributions | x | x | x | X |
| Loss (gain) on disposal of capital equipment | x | x | x | X |
| Loss (gain) on disposal of facilities and improvements | | | | |
| Loss (gain) on disposal of investments | x | x | x | X |
| Write down of capital assets | x | x | x | X |
| | 0 | 0 | 0 | 0 |
| Change in non-cash working capital account | x | x | x | X |
| **Cash generated (used by) operations** | 0 | 0 | 0 | 0 |
| **Investing activities:** | | | | |
| Purchase of investments | x | x | x | X |
| Purchase of capital assets: | | | | |
| Internally funded | x | x | x | X |
| Externally funded - equipment | x | x | x | X |
| - facilities & improvements | x | x | x | X |
| Proceeds on sale of investments | x | x | x | X |
| Allocations to non-current cash | x | x | x | X |
| Contributed assets put into service | x | x | x | X |
| **Cash generated (used by) investing activities** | 0 | 0 | 0 | 0 |
| **Financing activities:** | | | | |
| Capital contributions received | x | x | x | X |
| Endowment contributions received | x | x | x | X |
| Principal payments on long term debt | x | x | x | X |
| Proceeds from long term debt | x | x | x | X |
| Capital assets contributed | x | x | x | X |
| **Cash generated (used by) financing activities** | 0 | 0 | 0 | 0 |
| Increase (decrease) in cash and temporary investments | 0 | 0 | 0 | 0 |
| Cash and temporary investments, beginning of year | x | x | x | X |
| Cash and temporary investments, end of year | 0 | 0 | 0 | 0 |
| Non-current cash and investments at end of year | x | x | x | X |
| **Total cash and temporary investments and non-current investments at end of year** | | | | |
| **Additional information:** | | | | |
| **(1)** Non-cash working capital balance at end of period | X | x | x | X |
| **(2)** Total cash and temporary investments and non-current investments are comprised of: | | | | |
| Externally Restricted | X | x | x | X |
| Board Restricted | X | x | x | X |
| Unrestricted | x | x | x | X |
| | 0 | 0 | 0 | 0 |

**X Indicates Information required if applicable**

**HEALTH AUTHORITY BUSINESS PLAN** **Appendix IV**
**FINANCIAL PLAN TEMPLATE- IV**
**REGION :**

**SECTION D - CAPITAL EQUIPMENT PLAN**

**CAPITAL EQUIPMENT PLAN**
**(thousands of dollars)**

| **Net Book Value** | **1998-99 ACTUAL** | **1999-00 FORECAST** | **2000-2001 BUDGET** | **2001-2002 BUDGET** |
|---|---|---|---|---|
| Cost | X | X | X | X |
| Net Additions | X | X | X | X |
| Sub Total – Cost | 0 | 0 | 0 | 0 |
| Accumulated Amortization | X | X | X | X |
| Amortization - net of adjustments | X | X | X | X |
| Sub Total – Amortization | 0 | 0 | 0 | 0 |
| Net Book Value | 0 | 0 | 0 | 0 |
| **Proposed Acquisitions** | | | | |
| Capital equipment replacement | X | X | X | X |
| Specific initiatives equipment needs | X | X | X | X |
| Total Acquisitions | 0 | 0 | 0 | 0 |
| **Expected Funds Available** | | | | |
| From current operating surplus | X | X | X | X |
| Set aside in earlier years | X | X | X | X |
| Restricted contributions from other sources | X | X | X | X |
| Restricted contributions from Alberta Health and Wellness | X | X | X | X |
| Total Funds Available | 0 | 0 | 0 | 0 |
| Surplus (shortfall) in available funds | 0 | 0 | 0 | 0 |
| **Shortfall To Be Financed By:** | | | | |
| Short-term borrowings | X | X | X | X |
| Other financing arrangement | X | X | X | X |
| Long-term debt | X | X | X | X |
| Total borrowing for capital equipment | 0 | 0 | 0 | 0 |

**X Indicates Information required if applicable**

**Chief Executive Officer** **Date** **Chief Financial Officer** **Date**

# HEALTH AUTHORITY BUSINESS PLAN -
## HEALTH WORKFORCE PLAN TEMPLATE
### (As developed by the Provincial Health Workforce Steering Committee[1])

## SECTION A - DESCRIPTIVE DATA[2]

### A.1 Personnel Counts (as of March 31, 2000)

| | RN[3] | LPN | PT | OT | SLP | DMS |
|---|---|---|---|---|---|---|
| Regular Full-time | | | | | | |
| Regular Part-time | | | | | | |
| Temporary | | | | | | |
| Total | | | | | | |
| Leave of Absence | | | | | | |
| FTE Count | | | | | | |
| Casual | | | | | | |
| Casual FTE Count | | | | | | |

### A.2 Personnel Forecasts (as of March 31, 2001)

| | RN[3] | LPN | PT | OT | SLP | DMS |
|---|---|---|---|---|---|---|
| Regular Full-time | | | | | | |
| Regular Part-time | | | | | | |
| Temporary | | | | | | |
| Total | | | | | | |
| Leave of Absence | | | | | | |
| FTE Count | | | | | | |
| Casual | | | | | | |
| Casual FTE Count | | | | | | |

### A.3 Personnel Forecasts (as of March 31, 2002)

| | RN[3] | LPN | PT | OT | SLP | DMS |
|---|---|---|---|---|---|---|
| Regular Full-time | | | | | | |
| Regular Part-time | | | | | | |
| Temporary | | | | | | |
| Total | | | | | | |
| Leave of Absence | | | | | | |
| FTE Count | | | | | | |
| Casual | | | | | | |
| Casual FTE Count | | | | | | |

[1]Joint Health Authority/Government representation.
[2]Reporting limited to occupations where large numbers of Health Authorities reported experiencing shortages as outlined in the document *Current and Emerging Health Workforce Issues in Alberta – Questionnaire Findings, Final Report, March 1999, Alberta Health and Wellness.*
[3]RN –refers to Registered Nurses and Registered Psychiatric Nurses. See definitions section for more detail.

### A.4 Personnel Forecasts (as of March 31, 2003)

| | RN[3] | LPN | PT | OT | SLP | DMS |
|---|---|---|---|---|---|---|
| Regular Full-time | | | | | | |
| Regular Part-time | | | | | | |
| Temporary | | | | | | |
| Total | | | | | | |
| Leave of Absence | | | | | | |
| FTE Count | | | | | | |
| Casual | | | | | | |
| Casual FTE Count | | | | | | |

### A.5 Separations

| | RN[3] | LPN | PT | OT | SLP | DMS |
|---|---|---|---|---|---|---|
| Number of separations during the timeframe of April 1, 1999 to March 31, 2000 | | | | | | |

### A.6 Staff Older Than 50 Years of Age

| | RN[3] | LPN | PT | OT | SLP | DMS |
|---|---|---|---|---|---|---|
| Number of staff 50 or older as of March 31, 2000 | | | | | | |

## SECTION A - FOOTNOTES

Health Authorities should provide limitations or considerations required to explain the data they have submitted.

## SECTION B – ISSUES AND STRATEGIES

Health Authorities should identify their most significant current health workforce issues. For each issue stated, an indication of corresponding plans and strategies for addressing the issue must be provided.

## SECTION C – HUMAN RESOURCE PLANS FOR NEW BUSINESS PLAN STRATEGIES

For each new strategy identified in Health Authority Business Plans, which is predicted to have significant human resource impacts, appropriate human resource or staffing strategies are required. For each relevant strategy (identified by strategy name and number), corresponding text regarding human resource plans, should be outlined.

## SECTION D – ANNUAL REPORT REQUIREMENTS

Health Authorities must report on the results or progress of health workforce strategies completed or underway (related to Section B) in their annual reports.

## DEFINITIONS

**Employee:** An individual who agrees to work for an employer for a specified or indeterminate period of time in return for salary, wages and benefits, pursuant to that employee's collective agreement or employment contract. Include regular Health Authority employees and employees of voluntary facilities, but exclude employees of contracted agencies.

**Registered Nurse (RN):** Individuals practicing nursing duties who are registered with the Alberta Association of Registered Nurses (AARN) or the Registered Psychiatric Nurses Association of Alberta (RPNAA). For data reporting purposes, there will be a need to combine the data for registered nurses employed in acute care institutions with the data for registered nurses employed in community settings.

**Licensed Practical Nurses (LPN):** Individuals who are registered as a regulated member of the College of Licensed Practical Nurses of Alberta and practicing their profession.

**Physical Therapists (PT):** Individuals who are registered as a regulated member of the College of Physical Therapists of Alberta and practicing their profession.

**Occupational Therapists (OT):** Individuals who are registered as a regulated member of the Alberta Association of Regulated Occupational Therapists and practicing their profession.

**Speech Language Pathologists (SLP):** Individuals whose practice includes assessing, diagnosing, rehabilitating and preventing communication, oral motor and pharyngeal dysfunction and disorders. Speech Language Pathologists are currently unregulated in Alberta. However, there is voluntary registration with the Speech Language and Hearing Association of Alberta.

**Diagnostic Medical Sonographers (DMS):** Diagnostic medical sonographers operate ultrasound equipment to produce and record images of the motion, shape and composition of blood, organs, tissues and bodily masses such as fluid. Diagnostic medical sonographers have a post-graduate diploma in sonography. Most diagnostic medical sonographers were originally trained as registered nurses or x-ray technologists.

**Regular Full-time Employee:** An individual with regularly scheduled shifts who is required to work the number of hours specified for full-time employment in the collective agreement or employment contract.

**Regular Part-time Employee:** An individual who works regularly scheduled shifts, but the hours of work are less than those specified for full-time employment in the collective agreement or employment contract.

**Casual Employees:** An employee who works for irregular periods on a "call-in" basis, and does not occupy a regular or temporary position.

**Temporary Employees:** Individuals who are hired on a term-specific basis for project work, or to replace employees who are away.

**Employees on Leave of Absence:** Regular employees who are on leave of absence without pay (such as employees on maternity leave, educational leave, long-term disability, and workers' compensation).

**Full-Time Equivalent Employment for a Particular Occupation (FTE):** "Full-time equivalent employment" for a particular occupational group at a specific point in time, is calculated by dividing the total number of hours worked by all employees belonging to the specified occupational group by the standard number of hours worked by a full-time employee of that occupational group (as specified in the collective agreement or employment contract).

**Separations:** Permanent departures of individuals from employment as reported to Revenue Canada (excluding partial lay-offs), during the previous fiscal year (from April 1 to March 31).

# HEALTH AUTHORITY LONG TERM CAPITAL PLAN

Alberta Health and Wellness, Infrastructure, and Health Authorities will work together to define the elements of a long-term capital plan, including:

- Relationship to projected program and service needs;
- Defining capacity and utilization of health facilities, assessing the effectiveness of infrastructure utilization, and developing plans for the alternate use or divestiture of infrastructure that is surplus to health authority service needs.
- Seeking innovative, cost-effective partnership arrangements for meeting infrastructure needs, such as public private partnerships, and alternative long term care models to provide needed health infrastructure in an economical and effective manner or to deliver services in a more appropriate setting, and
- Defining information requirements and submission schedules to support the maintenance and expansion of the Integrated Health Facility Information System (IHFIS).

The Health Authority Business Plan should include, in the section on Long Term Capital Plan, a brief overview of the health authority's strategy for developing the long term capital plan, and confirmation that the Authority's long term capital plan will be developed or updated and submitted in 2000/01.

# PLANNER'S CHECKLIST FOR THE BUSINESS PLAN

The purpose of the checklist is to assist planners in ensuring that all required components of Health Authority Business Plans are included in the submission.

**Required components include:**

**8.1 Statement of Accountability**
**8.2 Vision**
**8.3 Mission**
**8.4 Opportunities and Challenges**
**8.5 Core Businesses**
**8.6 Goals**
**8.7 Required Areas of Strategy Development (including province-wide services where relevant)**
**8.8 Performance Measures, Targets, and Key Indicators**
**8.9 Long Term Capital Plan**
**8.10 Executive Summary of Information Systems, we//net, and technology plan attached as Appendix.**
**8.11 Financial Information**

- **Financial Plan**
- **Statement of Operations**
- **Statement of Changes in Financial Position**
- **Capital Equipment Plan**
- **Summary of Debt Level**

**8.12 Health Workforce Plan**

**Assumptions and Risks**

**Submitted as a separate document at the same time that the Business Plan is submitted.**